ANNA HEDLY GOEKE, M.A., LMFT

Insurance Verification Form

Patient Name: ____

Parent/Guardian Name: ____

Address: ____

City, State: ____ Zip: _________________________

Main Phone Number: _____________________________________ Ok to leave message? ( ) yes; ( ) no
( ) Home ( ) Work ( ) Mobile ( ) Other

Alternate Phone Number: __________________________________ Ok to leave message? ( ) yes; ( ) no
( ) Home ( ) Work ( ) Mobile ( ) Other

Email(s): ____

Patient Date of Birth: ________________

Primary Insurance Information

Insurance Company: ____

Effective Date: ____

Claims Address: ____

Insurance Co. Phone #: ____

Subscriber Name: ____

Relationship to Patient: Self Spouse Child Other

Subscriber Date of Birth: ____

Subscriber ID: ____

Subscriber Social Security #: ____

Group/Policy #: ____

In order to verify your insurance coverage, please fax this completed form to 206.888.4315

All insurance verification and billing is performed by

Prestige Medical Billing Company, Inc.
360.805.4829 (phone)
206.888.4315 (fax)